D. Center for Substance Abuse Treatment

1. Knowledge Development and Application

Authorizing Legislation - New legislation has been submitted.

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA	$115,297,000	$100,259,000	$100,259,000	$95,259,000	-$5,000,000

2001 Authorization

PHSA Section 501 . . . . . Indefinite

Purpose and Method of Operation

CSAT's Knowledge Development and Application program, begun in 1996, was designed to support development and testing of new and innovative treatment approaches, disseminate information on those systems shown to be most effective, and promote the adoption of best practices. A major focus has been on knowledge development with programs such as: *Marijuana Interventions* for both adults and youth; *Methamphetamine Treatment*; *Homelessness Collaborations*; *Criminal Justice Treatment Networks*; the *Community Action Grant* program; and *Treatment for Adolescent Alcohol Abuse and Alcoholism*. CSAT has continued to provide phase-out funding for the pre-1996 demonstration programs, such as the *Residential Treatment Program for Women and Their Children*, the *Pregnant and Post-Partum Women's Program*, and the *Rural, Remote, and Culturally Distinct* program, so that important evaluations of these programs could be completed.

Another major purpose of CSAT KD&A resources has been in support of a network of regionally-based curriculum developers, trainers, and consultants that is sensitive to the particular cultural and treatment needs of the people in that region *(the Addiction Technology Transfer Centers, or ATTC's)*. The types of services available from this network range from traditional training activities through on-site assistance and mentoring. In addition, CSAT's *Practice/Research Collaboratives* program, new in 1999, is designed to bring researchers, providers, and other community leaders together to review available data on substance abuse and substance abuse treatment, to develop plans for improving the services that are available, and to conduct evaluation studies needed to assure that the improvements are made.

KD&A funding supports the various evaluation projects underway at CSAT, including the *Persistent Effects of Treatment Study (PETS)*, *Managed Care Studies*, National Evaluation Data Services (NEDS),; and the review of *National Health Spending*. Data from this family of studies are providing valuable knowledge about "what works" in substance abuse treatment, the relative costs of treatment, and the long-term financial and human benefits of treatment. This knowledge is compared to overall societal costs of the failure to provide appropriate and effective treatment and rehabilitation of

substance abusers, whether through programs funded by Federal, State or local governments, or by the private sector.

Funding for the Knowledge Development and Application program during the last five years has been as follows:

	Funding	FTE
1996	$89,777,000	---
1997	155,868,000	---
1998 *	131,136,000	---
1999 *	115,297,000	---
2000 *	100,259,000	---

* Excludes funds transferred to the Targeted Capacity Expansion budget line.

Rationale for the Budget Request

The budget proposes a reduction of $5 million for this activity for 2001. CSAT will have sufficient available funding to support the continuation of all Knowledge Development and Application projects.

The KDA program will support actions required to transfer the Department of Health and Human Services' oversight of methadone/LAAM treatment programs from the Food and Drug Administration (FDA) to SAMHSA/CSAT *(Opioid Treatment Program Accreditation*). Institute of Medicine (IOM) and National Institutes of Health (NIH) consensus panels both recommended that a regulated system of accreditation for America's opioid agonist therapy clinics would be far superior to the current, outdated system of direct federal inspection. This responsibility has been assigned to SAMHSA and CSAT. When accreditation is fully implemented, anticipated outcomes include:

- A SAMHSA/CSAT accreditation program using procedures comparable to those used in the rest of the healthcare system. It is expected that opioid treatment programs/clinics will be modernized and brought into the mainstream of medical care.

- Accreditation surveys by treatment professionals. The accreditation process will promote continuous quality improvement procedures in each treatment clinic surveyed.

- Better treatment outcomes. Even more than the current estimate of 15% of patients should become stable and eligible for less intensive treatment in an office-based opioid therapy (OBOT) setting.

One of the domains identified by the National Treatment Plan was "Reducing Stigma and Changing Attitudes". To further incorporate recommendations from the NTP, CSAT intends to re-announce the Recovery Community Support Program (RCSP) which is designed to increase public understanding about consumers of substance abuse treatment services by collaborating with a grassroots constituency in support of recovery. The NTP recognized that this involves more than government entities; in fact, that the private sector including community groups, chambers of commerce, faith communities, and

private foundations must play a major role. To that end, CSAT will expand the scope of the RCSP initiative and increase stakeholder involvement in an effort to help eliminate the stigma associated with drug addiction and increase the recognition that drug and alcohol addiction are treatable diseases. The estimated amount of funding for this initiative in FY 2001 is $4 million.

Another of the NTP domains for which CSAT has already implemented preliminary recommendations is "Improving and Strengthening Treatment Systems". The Community Action Grant program, begun in FY 1999, provides communities with resources to develop consensus on adoption of a best practice and to implement that practice using providers who wish to work with others in their communities to improve the availability of substance abuse treatment. Estimated funding for this program in FY 2001 is $1 million.

The Addiction Technology Transfer Centers (ATTCs) are planned for continuation in FY 2001 in order to provide training and technical assistance resources to support the implementation of the NTP's recommendations. The NTP further recommends the development of training programs or courses for organizational leaders, focusing on management skills (e.g., hiring and retention issues, allocation of resources, infrastructure development, facilities improvement, etc.). The ATTCs also serve in the training of treatment providers in areas such as cultural competence, assessment and monitoring processes. The estimated amount of funding for this initiative in FY 2001 is $7.5 million.

A third NTP domain for which CSAT has laid the groundwork is "Connecting Research and Services". In FY 1999, the Practice/Research Collaboratives (PRC) program was begun, a program which brings researchers, providers, and other community leaders together to review available data on substance abuse and treatment and develop plans for improving the services that are available. Nine PRC Development grants were awarded in FY 1999. The second phase, Implementation Grants, to be funded in FY 2000, will allow grantees the opportunity to focus on the highest priority needs for both research and knowledge application by actually implementing the plan developed by the network. The estimated amount of funding for this initiative in FY 2001 is $3 million.

The distribution of KDA resources for selected program areas follows:

	1999 Actual	2000 Estimate	2001 Estimate	Difference
Recovery Community Support Program Amount (thousands)	$3,662	$3,662	$4,000	+$338
Number of Recovery Community Support Program Awards	19	19	22	+3
Community Action Grant Amount (thousands)	$1,000	$1,000	$1,000	---

	1999	2000	2001

		Actual	Estimate	Estimate Difference
Number of New Community Action Grant Awards	10	10	10	---
Addiction Technology Transfer Centers Amount (thousands)	$7,792	$7,792	$7,500	-$292
Number of Recovery Community Support Program Awards	14	14	14	---
Practice/Research Collaboratives Amount	$1,750	$3,000	$3,000	---
Practice/Research Collaboratives Awards	9	7	7	—

D. Center for Substance Abuse Treatment
2. Targeted Capacity Expansion

Authorizing Legislation - New legislation has been submitted.

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA	$55,089,000	$114,307,000	$114,307,000	$163,161,000	+$48,854,000

2001 Authorization

PHSA Section 501 . . . . . Indefinite

Purpose and Method of Operation

Fewer than two million of the more than five million persons who use and abuse alcohol and other drugs can be served through existing publicly-funded treatment systems. Substance abuse patterns vary greatly regionally and locally across the United States, from increased heroin use in the Northeast, to methamphetamine use in the Southwest and Midwest. This fact, coupled with the significant gap between available treatment capacity and current demand, often impedes the existing treatment system's ability to quickly and strategically respond to emerging needs. This program provides local communities the opportunity to create or expand the ability to provide an integrated, creative and community-based response to a targeted, well-documented substance abuse treatment capacity problem.

In FY 1998, CSAT initiated the Targeted Capacity Expansion (TCE) Program to provide for rapid and strategic responses to the demand for substance abuse treatment services that are more local and regional in nature. Examples of this included expansion of specialized services for women in three regions of Colorado, especially the underserved rural areas; expansion of outpatient methadone treatment in the under-represented areas of Chicago; and expansion of medical and non-hospital detoxification services in Philadelphia. Grants were awarded to municipal, County, State and tribal governments to help close the gap in treatment for emerging substance abuse problems. CSAT awarded 65 new grants in FY 1999. Included in this number were 35 grants to address the crisis that exists regarding substance abuse and HIV/AIDS in African American, Hispanic, and other racial and ethnic minority communities. The FY 2000 appropriation provided sufficient funding to continue all 106 grants that were awarded in FY 1998/99, and to make approximately 70 new TCE grant awards and 30 new TCE-HIV/AIDS grant awards.

The expected outcomes of the TCE program are:

- Increased accessibility to treatment;

- Reduced treatment gap;
- Reduced demand for illegal substances;
- Reduced or eliminated waiting time to enter treatment;
- Reduced number of chronic substance abusers.

While there are many sub-populations that are intended to be targeted with these funds, one in particular is youth. A 1991 report from the Office of Technology Assessment quoted estimates that suggested one of every five adolescents has at least one serious health problem. The report also concluded that there are major barriers that adolescents face in gaining access to treatment. Although adolescents who are both poor and members of racial or ethnic minority groups are at particular risk because of a lack of safety nets to help them negotiate these difficult years, the problems are not confined to this population. Issues related to availability, access, income, insurance coverage, legal challenges, and other potential social-psychological barriers are causing adolescent health issues to emerge in all sectors of society. Without a focused, coordinated approach, fostered by the multiple Federal, State, and local agencies that share a portion of the adolescent health treatment and prevention efforts, appropriate health promotion, early intervention, treatment, and necessary environmental support will continue to deteriorate, placing more of our Nation's youth at risk.

Funding for the Targeted Capacity Expansion program during the last five years has been as follows:

	Funding	FTE
1996	---	---
1997	---	---
1998 *	$24,732,000	---
1999 *	55,089,000	---
2000 *	114,307,000	---

* Reflects funding transfer from the Knowledge Development and Application budget line.

Rationale for the Budget Request

In support of ONDCP's goal of reducing the treatment gap, the FY 2001 request includes $163.1 million for the TCE program in 2001, an increase of $48.9 million over the 2000 current estimate. The proposed increase will fund approximately 100 new grants. The budget request would provide treatment for approximately 24,000 more individuals than the 2000 appropriation, a total of over 65,000 persons served by TCE-funded programs.

The design of the FY 2001 TCE program is threefold. First, and historically, the core program is designed to address gaps in treatment capacity at the local level by supporting rapid and strategic responses to demand for alcohol and drug abuse treatment services. The response to treatment capacity problems may include communities with serious, emerging drug problems (e.g., alcohol and marijuana for youth; methamphetamine in the Midwest; heroin and cocaine in the East), as well as

communities with innovative solutions to unmet needs. The core TCE initiative in FY 2001 will focus on vulnerable populations including, but not limited to, youth, women, homeless, co-morbid and rural. The estimated amount of funding for this activity in FY 2001 is $24.4 million.

Second, continuing the agenda set by the Congressional Black Caucus in FY 1999 and continued and expanded in 2000, the HIV/AIDS TCE initiative in African American, Hispanic and other ethnic/racial minority communities will be expanded. The estimated amount of funding for this activity is $15 million.

Third, the request includes an initiative designed to enhance both drug and alcohol treatment availability and accessability in small towns, rural areas, and mid-size cities for both adults and adolescents. This *Strengthening Communities* initiative will focus on encouraging the development of creative and comprehensive drug and alcohol treatment systems in areas with continuing major drug problems. Emphasis will be placed on helping communities help themselves to create: (1) primary care treatment and referral sites which would serve those users for whom brief interventions would be effective (e.g., marijuana and alcohol abusers) and refer those who require more intensive treatment to the speciality treatment system (e.g., heroin and crack cocaine addicts); (2) networks to ease addicts' access to services throughout the city, and transition recovering addicts back to the community; (3) early intervention services to provide low-intensity services to people whose substance-related problems are not yet severe; (4) comprehensive treatment centers designed to house different treatment modes under one roof in order to enhance cooperation between and among providers for better care; (5) detoxification plus treatment programs to detox patients economically and effectively and ensure their immediate entry to treatment; and (6) outreach activities which research has shown to be very effective in facilitating access to treatment. The estimated amount of funding for this activity is $34 million.

Associated with the TCE goal of increasing treatment capacity is the need to increase accessibility and eliminate systemic barriers to treatment. This is the focus of the *Strengthening Communities* initiative. In developing future policies applicable to TCE program, the possibility of including a matching requirement will be considered. Large proportions of alcohol and drug users are found in populations served by a variety of health and human service agencies. Primary care organizations, social service agencies, mental health, welfare, and child welfare agencies, jails and detention centers each contain significant numbers of drug- and/or alcohol-dependent individuals. There is some evidence, in fact, that substance-abusing individuals are more likely to be found or seek help from other than substance abuse treatment specialty service organizations. However, there is also evidence that the organization, financing, entitlement, and authorities of health and human service systems and other public systems have competing requirements that create barriers to access to the needed type and intensity of substance abuse treatment (rehabilitation) services. The FY 2001 proposal would implement inter-organizational models that improve access to substance abuse treatment services from other health, human service, and criminal justice organizations.

These proposals further the goals of the ***National Treatment Plan*** domain of "Closing the Treatment Gap". In order to close the treatment gap, it is necessary to develop a plan that would allow for the effective and appropriate care of all individuals in need of treatment regardless of demographic or other factors that may impede access to care. From preliminary NTP findings, three areas for attention

emerged: resource allocation; quality care and outcome measures; and, inter-system linkages. The core TCE program as well as the HIV/AIDS TCE program have focused on resource allocation (e.g., provision of full continuum of care, increased financial resources, sustained funding for identification, assessment, monitoring, etc.) and quality care and outcome measures (e.g., evidence-based standards for quality care and practices, consensus on critical data elements to measure quality of care and treatment outcomes for clients and providers).

The *Strengthening Communities* initiative continues with the first two areas while also addressing the third which is the issue of inter-system linkages, emphasizing the benefit of multiple systems working together to ensure that appropriate effective care is available to all individuals in need of treatment - a "No Wrong Door" approach. It is this initiative which seeks to create a framework for alcohol and drug treatment, so that regardless of which human service or criminal justice system an individual appears in, that person can be identified, assessed and treated in a clinically appropriate manner. These recommendations, taken together, provide a strategy to address the issues of ensuring that those in need of treatment actually receive it, ensuring that sufficient public and private resources are available, and ensuring that the types and levels of care needed are available. That is the major focus of the TCE program.

In developing future policies applicable to this program, the possibility of including a matching requirement will be considered.

D. Center for Substance Abuse Treatment
3. Substance Abuse Prevention and Treatment Block Grant

Authorizing Legislation - New legislation has been submitted.

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
Total . . .	$1,585,000,000	$1,600,000,000	$1,600,000,000	$1,631,000,000	+$31,000,000
(Treatment)	($1,204,600,000)	($1,216,000,000)	($1,216,000,000)	($1,239,560,000)	(+$23,560,000)

2001 Authorization

Substance Abuse Block Grant . . . . . Expired

Purpose and Method of Operation

The purpose of the SAPT Block Grant (SAPTBG) is to support treatment and prevention services for persons at risk of or abusing alcohol and other drugs. It is the cornerstone of States' substance abuse programs, accounting for 40% of public funds expended for treatment and prevention (1995). The SAPT Block Grant is designed to provide States the flexibility to plan, carry out and evaluate substance abuse prevention and treatment services to individuals and families; Federal funding for public treatment facilities, as a percentage of all funding being used at the State-level for substance abuse treatment, ranges from a low of 11% in one State to a high of 84% in another. In 1997, nineteen States reported that they received the majority of their funding for support of substance abuse from the SAPT Block Grant. Over 7,500 community-based organizations receive SAPTBG funding.

The SAPTBG is a formula-driven grant, and it includes numerous mandatory distributions and set-asides as prescribed in current law. Although reauthorization legislation has been introduced, P.L. 102-321 continues to be the legislative authority for distribution and management of the SAPTBG. For FY 2000, the appropriations act provided that "Each State's allotment for fiscal year 2000 for programs under this subpart [*Section 1933(b), Public Health Services Act*] shall be equal to such State's allotment for such programs for fiscal year 1999...." unless the total appropriated for the SAPTBG were less than 1999 appropriation. This one year hold harmless provision has been applied to FY 2000 State allotments.

Data collected from the SAPTBG application do not provide information on services delivered to one very vulnerable population, homeless persons. Recent changes to the SAPTBG application include new voluntary outcome measures for the "living status" of the clients. These data collection efforts will provide a baseline of information related to homeless persons served through CSAT programs and will

be available at the end of calender year 2000. States have, however, exercised their discretion to use SAPTBG funds, as well as State funds, to provide treatment to those who are homeless. Through other reporting mechanisms, States have indicated that homeless persons account for 21.3% of all admissions for substance abuse to publicly funded programs (Treatment Episode Data Set, 1999). The following are examples of programs funded through the SAPTBG that provide for the homeless:

- Pennsylvania -The development of a "Family Life Enrichment" program for homeless recovering persons and their families.

- Michigan - Outreach activity for IDUs at women's shelter and homeless shelters.

- California - Central intake mobile units to provide assessment and referral at two homeless shelters, the main county jail, and one county mental health regional office.

- New York - On-site evaluation/engagement and referral service to men and women living in more than ten New York City Homeless Shelters.

- Minnesota - Five programs for chronic and homeless users that demonstrated a cost-effective system for the care of chronic and homeless users so that community costs are reduced.

- Indiana - Intensive outpatient and intervention services targeted for the homeless men and women.

Expected outcomes from the SAPT Block Grant are as follows:

- Increased accessibility to treatment;
- Reduced treatment gap;
- Reduced demand for illegal substances;
- Reduced or eliminated waiting time to enter treatment;
- Reduced number of chronic substance abusers.

The federal Block Grant set-aside supports activities focusing on the development of outcome measures to assist the States in monitoring and evaluating treatment services funded by the SAPTBG. These activities include the Treatment Outcomes and Performance Pilot Studies (TOPPS I and II) to determine whether or not exportable models of outcome studies could be developed. As with the Targeted Capacity Expansion Program, measures will include the number of people served, outcomes which are still being determined, and customer satisfaction with the technical assistance provided to the States. Recent TOPPS accomplishments are described in the summary following this section.

The development of performance and outcome measures for the Substance Abuse Block Grant through a collaborative partnership has been identified as a critical need. Such an approach requires time to implement and complete, and TOPPS and other related activities are in place to accomplish this goal. States will report this information in their applications and the reliability and validity will be assessed

through project monitoring and periodic compliance reviews.

Funding for the Substance Abuse Prevention and Treatment Block Grant program during the last five years has been as follows:

	Funding	FTE
1996	$1,234,107,000	18
1997 *	1,360,107,000	18
1998 *	1,360,107,000	18
1999	1,585,000,000	18
2000	1,600,000,000	18

* Includes the $50 million SSI supplement provided by P.L.104-121.

Data Elements Used to Calculate State Allotments

FY 2000: The Congressional appropriation language specified that "...each State's allotment for fiscal year 2000 for programs under this subpart shall be equal to such State's allotment for such programs for fiscal year 1999." SAMHSA calculated the FY 2000 allotments such that no state would receive less in FY 2000 than it received in FY 1999. The factors and their data sources used to calculate the allotments in the FY 2000 table are:

- Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA website *http://www.bea.doc.gov/bea/dr/spitbl-d.htm#table2* - Table 2, Personal Income by State and Region, 1993-1997, release date 9/14/98, also available from *http://www.bea.doc.gov/bea/ar1098rem/table1.htm.*

- Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census website, text file AG9797.txt, 1990-to-1997 Annual Time Series of Population Estimates by Age and Sex, By Single Year of Age and Sex, public release date 7/21/98. Census website is *http://www.census.gov/population/estimates/state/stats/ag9797.txt.* (data as of 7/1/97).

- Total Taxable Resources (TTR) - Office of Economic Policy, Department of the Treasury, provided directly to OAS via e-mail, filename NM98EST.wk4, release date 9/30/98, Total Taxable Resources, 1994-1996.

- Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were

not included in the 1990 census.

- A Cost of Services Factor which includes the following: Fair Market Rents for the Section 8 Housing Assistance Payments Program — Fiscal year 1997, from the U.S. Department of Housing and Urban Development, *Federal Register*, September 20, 1996, Vol. 61, No. 184, pages 49576-49635, from website *http://www.hud.gov* and then *ftp@ftp.aspemsys.com*. 1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1993 hourly hospital wages developed from the FY 1997 HCFA Hospital Inpatient Prospective Payment System Wage Rates [published in the *Federal Register*, August 30, 1996, Vol. 61, Number 170, pages 46165-46215 with corrected data published in the *Federal Register* December 19, 1996, Vol. 61, Number 245, pages 66919-66923] in the HCFA public use file "HCFA Hospital Wage Index Survey File" of Hospital Inpatient Prospective Payment System FY 1997 Rates downloaded from website *http://www.hcfa.gov/stats/pufiles.htm* and corrected per the December 1996 revisions.

FY 2001: The factors and their data sources used to calculate the allotments in the FY 2001 table are:

- Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA web site http://www.bea.doc.gov/bea/regional/spi/summary.htm State Personal Income, 1994-1998, release date 7/27/1999.

- Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census website, text file AG9898.txt, Population Estimates for the U.S. and States by Single Year of Age and Sex: July 1, 1998, public release date 6/15/1999. Census web site is http://www.census.gov/population/estimates/state/stats/.

- Total Taxable Resources (TTR) - Office of Economic Policy, Department of the Treasury, provided directly to OAS via e-mail, filename NM99EST.wk4, release date 9/30/1999, Total Taxable Resources, 1995-1997, now also available on the Treasury web site http://www.treas.gov/ttr.

- Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were not included in the 1990 census.

- A Cost of Services Index Factor, updated for this fiscal year under a three-year periodic

update, which includes the following:

Fair Market Rents for the Section 8 Housing Assistance Payments Program — Fiscal Year 2000, downloaded from the HUD web site http://www.huduser.org/datasets/fmr: (a) fmr2000f.dbf, dbase file, released 10/1/99, created 9/23/99 (dbase is the only machine-readable format in which the raw data are offered); (b) fmr2000f.txt, text file, FMR data record layout and file description, released 10/1/99, created 9/27/99; (c) 2000f_pre.doc, Word file, Federal Register preamble of the FY2000 FMR calculations, released 10/1/99; and (d) fmrover.wp, WordPerfect version of the Federal Register preamble.

Metropolitan Areas, 1999, released by the Office of Management and Budget 6/30/99, filename MSA99.pdf; used by HUD in development of FMR rates.

Changes in Metropolitan Areas as Defined by the Office of Management and Budget Since June 30, 1999, filename MAUPDATE.txt, released 6/30/99, Bureau of the Census.

1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1996 hourly hospital wages developed from data collected for the establishment of FY 2000 HCFA Hospital Inpatient Prospective Payment System Wage Rates, collected from the HCFA Internet web site http://www.hcfa.gov/stats/pufiles, publically available on August 17, 1999. Both executable and zip versions of the data file WAGEDATA.F96 were available on the web site as 1.2 MB self-extracting files which decompressed to a 5 MB fixed length (i.e. "flat") ASCII file consisting of 5,038 records (one record for each unique facility reporting to HCFA) - the executable version was downloaded and decompressed. Also downloaded was the file for the data record layout (WDF2000), which was available in several formats. Guidance was also provided by HCFA regarding relevant changes which occurred in reporting format between the FY 1997 and FY 2000 hospital wage data releases.

Rationale for the Budget Request

The FY 2001 request includes a $31 million increase for the SAPT Block Grant, for a total program level of $1.631 billion. Because the cost of treatment is subject to inflationary increases year-to-year, the number of persons being provided treatment services with Federal SAPT Block Grant funding in FY 2001 will remain at approximately the same level as in FY 2000.

The National Drug Control Strategy established by ONDCP has set a goal of closing the drug treatment gap by 50% by the year 2007. The Substance Abuse Prevention and Treatment Block Grant will continue as the dominant funding vehicle for commitment of resources in the continuing attack on the nationwide substance abuse problems. Block Grant increases are necessary to sustain progress

in reducing the number of substance abusers in this country. Likewise, the commitment of Block Grant funding toward critical prevention initiatives, particularly those focused on the nation's youth, must also remain strong if growth in the number of new users of substances of abuse is to be curtailed.

The Office of National Drug Control Policy (ONDCP) has charged SAMHSA with the primary responsibility to implement a National Treatment Outcomes Monitoring System (NTOMS) by the year 2002. The purpose of NTOMS is to collect data on an ongoing basis and provide drug treatment providers nationwide with a source of information needed to identify changes in drug abuse treatment outcomes and to identify program-level determinants of change. Outcomes monitoring focuses on assessment of participants' functioning before, during, and following a specific treatment episode, and will be used by policy makers and funding entities, such as Federal and State government agencies and insurers, to hold treatment programs accountable.

CSAT and the Office of Applied Studies (OAS) will collaborate on NTOMS development and implementation, and this effort will also involve coordination with a number of other Departments, including the Department of Veterans Affairs and the Department of Justice. The first-year (2001) costs of NTOMS are estimated at $5 million, to be funded from the SAPT Block Grant set-aside. Set-aside funding will be available for NTOMS since SAMHSA will receive $12 million additional from the Secretary's 1% evaluation resources to partially fund the National Household Survey on Drug Abuse (NHSDA).

PROGRAM ACCOMPLISHMENT

Program/Initiative: TREATMENT OUTCOMES AND PERFORMANCE PILOT STUDIES (TOPPS I)

Goal:

To conduct a series of pilot studies designed to analyze specific components of selected State substance abuse treatment delivery systems in terms of performance and outcome, defining appropriate measures and incorporating them into current State data bases. This initiative was designed to enable the States to improve State system capability, standardization, and accountability. Four States addressed outcomes measures for pregnant women and women with dependent children population; two States addressed outcomes measures for cultural diversity; one State addressed outcome measures for parents/guardians of adolescents in substance abuse treatment.

Findings:

Maryland

The study goal was to develop methodologies for using an existing State client database to determine which publicly-funded adult outpatient treatment programs are most effective, while controlling for differing characteristics of the client populations.

Preliminary Results -

- 40.5% of clients successfully completed treatment
- 70.6% of clients were employed at discharge
- 39.3% of clients reduced their frequency of substance use during treatment
- 73.5% of clients were reported to be using no substances at discharge

Minnesota

The goal was to study the role of parents/guardians in adolescent treatment, and the relationship between their involvement and adolescent treatment outcome.

Preliminary Results -

- The likelihood of abstinence in the 3 months following treatment was almost two times as high (1.8) for adolescents whose parents participated in aftercare than for adolescents whose parents did not participate in aftercare

- Comparing pre-treatment to 3-months post-treatment, the percentage of adolescents saying they experience "a fair amount" or "a lot" of family conflict was significantly reduced from 63.0% to 38.6%.

- In the 3 months following treatment, 35.3% of the adolescents were abstinent from all substances, 46.5% had a 1-2 month stretch of abstinence, and 18.2% had less than one month of continuous abstinence.

- Use of marijuana was reduced by 58.6% when comparing the proportion of adolescents using marijuana in the thirty days prior to treatment to the proportion using marijuana in the thirty days prior to the 3 month post-treatment interview. The mean number of days using marijuana is reduced by 74.5% (comparing the 30 days prior to treatment to the 30 days prior to the 3 month post-treatment interview).

- Involvement in illegal activities was reduced by 34.7% when comparing the proportion of adolescents involved in illegal activities in the thirty days prior to treatment to the proportion involved in illegal activities in the thirty days prior to the 3 month post-treatment interview.

- The likelihood of binge drinking was reduced by 62.9% comparing pre-treatment binge drinking and post-treatment binge drinking.

- Nearly three-quarters (72.7%) of parent/guardians said that they believed treatment was helpful to their child "a fair amount" or "a great deal". Nearly three-quarters (72.6%) of parent/guardians said that they believed treatment was helpful to themselves "a fair amount" or "a great deal".

Oklahoma

The goal was to use administrative data to obtain performance measurement of publicly-funded substance abuse treatment.

Preliminary Results -

- Among the DUI convictions, 1,699 (22.4%) of the FY 1994 cohort had a DUI conviction in the 18 months prior to treatment. Of those, 1,045 (62%) did not have a DUI conviction in the 18 months following treatment.

- A total of 469 clients linked with the Department of Correction Offense File in FY 1994 were found to have received treatment while incarcerated. Among those clients, 15% returned to prison during the two years following release compared to the 20% state rate of second year recidivism after release

- A total of 462 clients in FY 1995 were found in the tax databases for each of the two years before and after their treatment episodes. Sixty-two percent of the clients in the two year study were found to have positive gains in income.

Substance Abuse and Mental Health Services Administration

Substance Abuse Prevention and Treatment Block Grant, FY 1999 - 2001

State / Territory	FY 1999 Actual	FY 2000 Prerescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Increase/ Decrease
Alabama	$21,666,850	$22,197,312	$22,197,312	$23,130,113	$932,801
Alaska	3,440,623	3,440,623	3,440,623	3,272,688	(167,935)
Arizona	27,127,147	27,127,147	27,127,147	27,481,356	354,209
Arkansas	11,280,281	11,335,103	11,335,103	12,100,889	765,786
California	216,995,385	223,282,608	223,282,608	236,544,535	13,261,927
Colorado	20,297,398	20,297,398	20,297,398	21,508,558	1,211,160
Connecticut	16,405,660	16,405,660	16,405,660	15,837,411	(568,249)
Delaware	5,553,544	5,553,544	5,553,544	3,600,915	(1,952,629)
District Of Columbia	4,952,603	4,952,603	4,952,603	3,153,850	(1,798,753)
Florida	80,256,078	81,263,908	81,263,908	87,180,290	5,916,382
Georgia	40,710,806	41,396,779	41,396,779	45,056,623	3,659,844
Hawaii	6,810,019	6,983,864	6,983,864	6,991,841	7,977
Idaho	5,943,750	5,943,750	5,943,750	6,366,555	422,805
Illinois	61,138,459	61,204,360	61,204,360	65,580,101	4,375,741
Indiana	32,509,147	32,509,147	32,509,147	30,949,619	(1,559,528)
Iowa	12,542,219	12,542,219	12,542,219	12,443,420	(98,799)
Kansas	10,996,215	11,060,004	11,060,004	11,768,766	708,762
Kentucky	19,105,313	19,276,066	19,276,066	19,958,090	682,024
Louisiana	24,828,318	24,828,318	24,828,318	25,246,379	418,061
Maine	5,943,750	5,943,750	5,943,750	5,429,083	(514,667)
Maryland	29,389,161	29,389,161	29,389,161	31,262,343	1,873,182
Massachusetts	33,214,336	33,214,336	33,214,336	30,586,414	(2,627,922)
Michigan	56,510,128	56,510,128	56,510,128	51,310,085	(5,200,043)
Minnesota	20,877,637	20,877,637	20,877,637	21,226,211	348,574
Red Lake Indians	514,557	514,557	514,557	523,148	8,591
Mississippi	13,142,417	13,183,451	13,183,451	13,690,509	507,058
Missouri	24,121,029	24,223,136	24,223,136	25,305,461	1,082,325
Montana	5,584,314	5,584,314	5,584,314	4,318,391	(1,265,923)
Nebraska	7,472,914	7,472,914	7,472,914	7,734,782	261,868
Nevada	9,441,768	9,619,717	9,619,717	10,830,939	1,211,222
New Hampshire	5,943,750	5,943,750	5,943,750	4,185,818	(1,757,932)
New Jersey	45,115,909	45,115,909	45,115,909	46,211,746	1,095,837
New Mexico	8,261,541	8,261,541	8,261,541	8,380,204	118,663
New York	104,711,026	104,711,026	104,711,026	109,137,383	4,426,357
North Carolina	33,404,937	33,680,936	33,680,936	34,675,689	994,753
North Dakota	3,817,151	3,817,151	3,817,151	3,258,974	(558,177)
Ohio	65,062,211	65,062,211	65,062,211	56,761,044	(8,301,167)
Oklahoma	16,185,602	16,559,798	16,559,798	17,358,753	798,955
Oregon	15,114,749	15,268,109	15,268,109	15,568,706	300,597
Pennsylvania	57,670,348	57,670,348	57,670,348	56,887,555	(782,793)

Substance Abuse and Mental Health Services Administration

Substance Abuse Prevention and Treatment Block Grant, FY 1999-2001

State / Territory	FY 1999 Actual	FY 2000 Prerescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Increase/ Decrease
Rhode Island	5,943,750	5,943,750	5,943,750	5,355,998	(587,752)
South Carolina	18,527,032	18,663,663	18,663,663	19,786,552	1,122,889
South Dakota	3,529,799	3,529,799	3,529,799	3,065,201	(464,598)
Tennessee	25,624,806	25,999,363	25,999,363	28,466,011	2,466,648
Texas	122,543,553	124,118,032	124,118,032	128,039,240	3,921,208
Utah	13,729,782	14,551,928	14,551,928	15,884,143	1,332,215
Vermont	3,774,105	3,774,105	3,774,105	2,510,841	(1,263,264)
Virginia	39,245,298	39,245,298	39,245,298	41,170,203	1,924,905
Washington	30,769,108	31,732,096	31,732,096	33,949,066	2,216,970
West Virginia	8,434,819	8,434,819	8,434,819	8,474,804	39,985
Wisconsin	24,530,479	24,530,479	24,530,479	24,984,238	453,759
Wyoming	2,452,377	2,452,377	2,452,377	1,706,716	(745,661)
State Sub-total	**1,483,163,956**	**1,497,200,000**	**1,497,200,000**	**1,526,208,250**	**29,008,250**
American Samoa	263,259	265,751	265,751	270,900	5,149
Guam	749,439	756,531	756,531	771,189	14,658
Northern Marianas	243,965	246,274	246,274	251,045	4,771
Puerto Rico	19,823,590	20,011,195	20,011,195	20,398,911	387,716
Palau	85,113	85,919	85,919	87,584	1,665
Marshall Islands	251,788	254,171	254,171	259,096	4,925
Micronesia	596,069	601,710	601,710	613,368	11,658
Virgin Islands	573,026	578,449	578,449	589,657	11,208
Territory Sub-total	**22,586,250**	**22,800,000**	**22,800,000**	**23,241,750**	**441,750**
SAMHSA Set-Aside	**79,249,794**	**80,000,000**	**80,000,000**	**81,550,000**	**1,550,000**
GRAND TOTAL	**$1,585,000,000**	**$1,600,000,000**	**$1,600,000,000**	**$1,631,000,000**	**$31,000,000**

THIS PAGE LEFT INTENTIONALLY BLANK